PARTNERS in Family Practice Ltd.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____

Date of Birth:_____ Phone:_____

Address:_____

_____

I, _____, authorize _____
to release my medical records to: (Physician's name with old records)
(Please include a phone # or address)

Partners in Family Practice, Ltd.
Phone: 478-4132 4048 Dressler Rd. N.W. Suite 203
Fax: 330-478-3341 Canton, Ohio 44718

As you may know, the HIPAA Privacy Rule permits a provider who is a covered entity to disclose a complete medical record including portions that were created by another provider, assuming that the disclosure is for a purpose permitted by the Privacy Rule, such as treatment!

The following information is authorized for release (check all appropriate items):

☐ Emergency Room Report(s)	☐ Radiology Reports	☐ Lab Reports
☐ History & Physical	☐ Discharge Summary	☐ Pathology Reports
☐ **Complete Medical History**	☐ Operative Reports	☐ EKG Reports

☐ Other _____

I understand and acknowledge that my medical records may contain alcohol/drug abuse and/or HIV/AIDS and/or mental health information, and I expressly consent to the release of any such information contained in the records designated above. **This release expires 1 year from the date of signature unless otherwise, indicated by patient.**

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (Relationship) Date

_____ _____
Signature of Witness Date

(330) 478-4132 Phone

Partners in Family Practice, Ltd.
4048 Dressler Rd., N.W., Suite 203
Canton, Ohio 44718

(330) 478-3341 Fax

Name: _____ **Race:** White / Black/African American / American Indian
Last Name First Name Middle Name Asian / Hawaiian / Other / Unknown / Declined

Prefix: □ Miss □ Mr. □ Mrs. □ Ms. **Suffix:** □ I □ II □ III □ IV □ Jr. □ Sr. **Ethnicity: Hispanic/Latino? YES / NO**

Nickname/Preferred Name: _____ **Maiden Name:** (if applicable) _____

Date of Birth: _____/_____/_____ **Sex:** □ Female □ Male **Social Security #** _____/_____/_____

Marital Status: □ Divorced □ Married □ Single □ Separated □ Widowed □ Other

Address: _____
Street City State ZipCode

Preferred Method of Contact for Appointment Reminder? Home Phone Call , Cell Phone Call , Text Message
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Email Address: _____ **Employer Name:** _____

Emergency Contacts (if patient is a minor, mothers AND father's information MUST be completed):
1.) Mother / Spouse: ↓ **<u>*IF YOUR PARENT HOLDS INSURANCE ON YOU WE NEED ADDRESS/PHONE#</u>**

_____
Name Address (if different from above) City State Zip Phone

2.) Father / Spouse: ↓

_____
Name Address (if different from above) City State Zip Phone

3.) Emergency Contact: ↓

_____
Name Address City State Zip Phone

4.) Legal Guardian: ↓

_____
Name Address City State Zip Phone

5.) Family Member NOT Living in Home/ Closest Relative: ↓

_____
Name Address City State Zip Phone

Family Member Names Who Are Patients Here: _____

<u>Insurance Coverage:</u> (*IF INSURANCE IS THROUGH PARENT WE NEED ALL THEIR INFORMATION)
Primary Insurance: _____ **Policy #: *** _____ **Group #** _____
Insured Name: * _____ **Insured Date of Birth:*** _____ **Copay $**_____
Insured Social Security #: * _____ **Effective Date:** _____/_____/_____
Insured Employer: * _____ **Phone:*** _____
Insurance Address: _____

<u>Insurance Coverage:</u> **(IF YOU HAVE A THIRD INSURANCE COMPANY PLEASE WRITE INFO ON BACK)**
Secondary Insurance: _____ **Policy** _____ **Group #** _____
Insured Name: _____ **Insured Date Birth**_____ **Copay $**_____
Insured Social Security #: _____ **Effective Date:** _____/_____
Insured Employer: _____**Phone**_____
Insurance Address: _____

****

Preferred Pharmacy: _____ ***Phone***_____

PARTNERS IN FAMILY PRACTICE, LTD., 4048 Dressler Rd., N.W., Suite 203, Canton, Ohio 44718

Legal Authorizations

MINOR CONSENT

I/We, the undersigned parent(s) or legal guardian of _____ a minor, do hereby authorize and consent to any medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff at Partners in Family Practice, Ltd. under the provisions of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis and/or treatment being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his or her best judgment may deem advisable. I also authorize the following people to bring my minor child to the office for treatment: _____

Parent/Guardian Signature: _____ Date: _____

HIPAA ACKNOWLEDGEMENT

I, _____, the undersigned Patient or the parent and/or legal guardian of the patient acknowledge that I have received a copy of Partners in Family Practice's Notice of Privacy Practices. **Our practice leaves ALL normal results on your answering machine. If you would prefer not to receive normal results on your answering machine please notify us.** We will honor all requests within reason but please know that legally we do have the right to contact you with any means available in an emergency.

I wish to be contacted in the following manner (PLEASE CHECK ALL THAT APPLY)

- ☐ Home Telephone: _____
  - ☐ OK to leave a message with detailed Information
  - ☐ Leave message with call back number Only
- ☐ Cell Phone Number: _____
  - ☐ OK to leave a message with detailed Information
  - ☐ Leave message with call back number Only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed Information
  - ☐ Leave message with call back number Only
- ☐ Written Communication (CHECK ALL THAT APPLY)
  - ☐ OK to mail to my home address
  - ☐ OK to fax to this number: _____
  - ☐ Other: _____

CANCELLATION / MISSED APPOINTMENTS POLICY

Due to the very busy schedule of our providers, we have found the need to develop a policy for cancellations and missed appointments. **All appointments must be cancelled or rescheduled 5 hours in advance.** If you fail to give appropriate notice on 3+ occasions, treatment at this office will be terminated. It will be your responsibility to find another private physician or contact your insurance carrier for further treatment. There could be a $10.00 fee to call in medications if it is due to a missed appointment or cancellation that was not done within the 24 hour period (at the discretion of the provider). This will have to be paid prior to your next appointment time.

FINANCIAL POLICY / AUTHORIZATIONS

We ask for co-payments, co-insurances and deductibles at the time of service. A copy of your insurance card is required at the time of the initial service and yearly as well as any time your insurance coverage changes. All self-pay patients are asked for $100 down for a new patient and $50 down payment for established patients. Balances paid on the same day will receive an additional 20% discount; balances paid within 30 days will receive a 10% discount. All balances held after 30 days will NOT receive a discount and will be due and payable prior to next appointment.

With the proper information, we will prepare and file your insurance claims as a service to you free of charge. In some cases, you may need to file your own claims. We will assist you by providing you with an itemized statement that you can attach to your form and submit. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We CANNOT guarantee payment of your claims, and our office will NOT accept responsibility of negotiating claims with your insurance companies or other persons. The Patient is responsible for payment of his/her medical care, regardless of the status of the claim. If your insurance company pays only a portion of your bill or rejects the claim, any contact or explanation should be made to you, the policy holder. Reduction or Rejection of your claim by your insurance company does not relieve your financial obligation that you have incurred with our office. If necessary we will lend assistance when needed to help process your rejected claims. **It is ultimately your responsibility to make sure we have your correct insurance card on file at the time of service and if the claim is denied for "no authorization," you will be responsible for payment. It is also your responsibility to verify coverage for your particular plan and if your insurance company denies claim payment for a plan provision, you will be responsible for the balances.**

*There is a $20 charge to fill out disability forms with a 48 hour notice.
*There is a $35 charge for a written NSF check.
*We reserve the right to charge for transfer of medical records
*We have the authorization to verify employment if needed

By signing below I agree that all of the above is true to the best of my knowledge. I agree to give Partners in Family Practice, Ltd. Permission to bill my insurance company on my behalf. I agree that ultimately I am responsible for all incurred costs not covered by my insurance company and it is my responsibility to know the terms of coverage for my insurance plan.

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

_____

Patient Signature and/or Parent(s) or Legal Guardian of Patient **Date**

Medical Information

Name_____ DOB_____

Reason for today's visit _____

Past Medical History : Have you ever had any of the following ? Check box if "Yes"

Heart

_____ Hypertension
_____ Hyperlipidemia
_____ Heart Attack
_____ Congestive Heart Failure
_____ Heart Murmur
_____ Heart Valve Disorder
_____ Artial Fibrillation
_____ Peripheral Vascular Disease
_____ Deep Vein Thrombosis
_____ Aortic Aneurysm
_____ Carotid Stenosis

Nervous System

_____ Seizure/ Epilepsy
_____ Stroke
_____ Head Injury
_____ Parkinsons
_____ Migraines
_____ Alzheimers/Dementia
_____ Mental Retardation
_____ Aneurysm
_____ Hydrocephalus/Shunt
_____ Peripheral Neuropathy
_____ Multiple Sclerosis

Musculosketetal

_____ Rheumatoid Arthritis
_____ Osteoarthritis
_____ Degenerative/Herniated Disc
_____ Systemic Lupus Erthematosis
_____ Fibromyalgia
_____ Gout

Blood

_____ Anemia
_____ Blood Transfusion
_____ Bleeding Disorder

_____ Clotting Disorder
_____ Sickle Cell
_____ Thalassemia

Ears/Nose/Throat

_____ TMJ
_____ Menieres Disease
_____Allergic Rhinitis

Female Problems

_____ Ovarian Cyst
_____ Endometriosis
_____ Uterine Fibroids
_____ Abnormal Pap Smear
_____ Polycystic Ovarian Syndrome
_____ Breast Mass
_____ Miscarriage/Abortion
_____ HPV

Lungs

_____ COPD
_____ Asthma
_____Emphysema
_____Sleep Apnea
_____ Pulmonary Embolism
_____ Asbestos Exposure
_____ Positive PPD
_____ Tuberculosis
_____ Lung Nodules
_____ Sacoidosis
_____ Cystic Fibrosis
_____ Polio

Psychiatry

_____ Anxiety
_____ Depression
_____ Bioplar Disorder
_____ ADHD
_____ ADD
_____ Learning Disability
_____ Speech Delay
_____ Obessive Compulsive
_____ Schizophrenia

Congential

_____ Congenital Heart Defect
_____ Down Syndrome
_____ Turners Syndrome
_____ Cleft Lip/Cleft Palate
_____ Prematurity
_____ Congenital Hearing Loss

Infections

_____ HIV
_____ Herpes Simplex Virus
_____ Chlamydia
_____ Gonorrhea

_____ Syphillis
_____ Genital Warts
_____ HPV

Male Problems

_____ BPH-Prostate Problems
_____ PSA Elevation
_____ Erectile Dysfunction
_____ Testicular Mass
_____ Low Testosterone

Cancer

Please name typle of CANCER you have had

_____

Please List Specialist you see _____

_____

Gastrointestinal

_____ GERD/Reflux
_____ Hiatal Hernia
_____ Diverticulosis
_____ Colon Polyps
_____ Gastric/Peptic Ulcer
_____ Hepatitis
_____ Ulcerative Colitis
_____ Crohns Disease
_____ Irritable Bowel Syndrome
_____ Fatty Liver Disease
_____ C.Diff Diarrhea
_____ Pancreatitis

Endocrine

_____ Diabetes Type 1
_____ Diabetes Type 2
_____ Hypothyrodism
_____ Goiter
_____ Osteoporosis
_____ Osteopenia

Kidney/Bladder

_____ Polycystic Kidney
_____ Kidney Stones
_____ Kidney Failure
_____ Dialysis
_____ Recurrent UTI
_____ Incontinence/Overactive Bladder

Skin

_____ Psoriasis
_____ Eczema
_____ Rosacea

Eyes

_____ Cataracts
_____ Glaucoma

_____ Mascular Degeneration
_____ Retinal Detachment
_____ Diabetic Retinopathy

Childhood Diseases

_____ Chicken Pox
_____ Measles
_____ Mumps
_____ Rubella
_____ Other _____

Name:_____ DOB:_____

Surgeries: Have you had any surgeries ? Check Box is "yes" and write date of Surgery

_____Hernia/ what type?
_____Appendix
_____ Gallbladder
_____Gastric Bypass
_____ Ear Tubes
_____ Tonsils
_____ Adenoids
_____ Sinus Surgery
_____ Splenectomy
_____ Cataracts
_____ Laser Eye Surgery
_____ Lasix

_____ Colonoscopy
_____ EGD
_____ Joint Replacement? What joint?_____
_____ Coronary Artery Bypass/Open Heart Surgery
_____ Heart Valve Replacement? What valve?____
_____ Heart Catheterization
_____ Heart Stent Placement
_____ Heart Angioplasty
_____ Carotid Surgery
_____ Aneurysm Repair
_____ Greenfield Filter

Female

_____ Tubal Ligation
_____ Colpscopy
_____ Leep/Precervial Surgery
_____ D&C
_____ Endometrial Ablation
_____ Breast
_____ Hysterectomy/ovaries removed?

Male

_____ Vascetomy
_____ TURP

Other Surgery _____

Medications:

Medication Name	Dosage (mg)	# Pills Taken	How many times per day

Allergies:	Reaction
Medication/Other	

Social History :

Alcohol Use: ___ Never ___ Former ___ Current , Amount_____
Tobacco Use: ___ Never ___ Former ___ Current , Amount_____
Illegal Drug Use: ___ Never ___ Former ___ Current , Amount_____
Type of Drugs used_____
Caffeine Use: ___ Never ___ Former ___ Current, Amount_____

Marital Status?_____
What is your highest level of education?_____
What is your occupation?_____
Are you currently exposed to Second Hand Smoke ? YES or NO
If YES, by whom?_____
Have you ever been exposed to any hazardous materials? (Lead, Asbestos, etc) YES or NO
If YES, what material were you exposed to and when ?_____
Are you at increased risk of infection? (TB, Hepatitism STD, etc)
YES or NO If YES, Why?_____
Do you wear your seat belt riding or driving a car? YES or NO
Name:_____ DOB:_____
Do you have a routine exercise plan? YES or NO

How many times per week do you exercise?_____
Have you ever or do you currentlt serve in the military ? YES or NO
If YES, what branch of military?_____
Is there a history of domesitc violence (physical or verbal)? YES or NO
If YES, by whom?_____
Do you have a Living Will/POA for Health Care ? YES or NO
Please provide a copy for your chart

Hand Dominance ? Are you right handed _____, left handed _____, both_____

Name:_____ DOB:_____

Family History: ** Maternal =Mother's Family , ** Paternal = Father's Family

	Mother	Father	Brother	Sister	Maternal Grandmot	Maternal Grandfat	Paternal Grandmo	Paternal Grandfat	Children
Heart Disease									
High Blood Pressure									
Diabetes									
Thyroid									
Cancer (TYPE)									
Kidney									
Stroke									
Osteoporosis									
Mental Illness									
Other (please describe)									

Please indicate by circling if you are experiencing any of the following symptoms at this time:

Fever/chills	Nausea/vomiting/diarrhea/constipation	
Eye pain/vision changes	Abdominal pain	Seasonal Allergies
Headache/head injury	Blood in stool	Rash
Chest pain	Blood in urine	Change to Skin Lesion
Irregular Heart beat	Burning with urination	
Shortness of breath	Seizures/tremors	
Wheezing	Anxiety/depression	

THIS SECTION MUST BE FILLED OUT COMPLETELY FOR A INTAKE NURSE TO CALL

Please indicate the last time you have had a :

Dental Exam_____
Vision Exam_____
Flu Vaccine_____
Pneumonia Vaccine_____
Tetanus Vaccine_____
Hepatitis Vaccine_____
TB Test_____

For Women Only:

Is there any change of pregnancy today? YES or NO
Age at onset of menstrual peroid ?_____ Date of last menstrual peroid?_____
Do you do regular breast exams? YES or NO
Do you use any form of birthcontrol? YES OR NO What type?_____
Number of pregancies_____ Number of live births_____
Number of abortions_____ Number of miscarriages_____

Please indicate the year of your last:

Breast Exam _____
Mammogram _____
Pap Smear_____
HPV test_____
Dexa_____
Colon Cancer Screening_____
Lipid panel_____

For Men Only:

Please indicate the year of your last:
Rectal Prostate Exam_____
PSA Level_____
Colon Cancer Screening_____
Lipid Panel_____

For Diabetics Only:

Please indicate the **DATE** of your last:
Hemoglobin A1C_____ Result:_____
Eye Exam_____ What doctor_____
Foot Exam_____ What doctor_____
Do you see an Endocrinologist? YES or NO If YES which doctor?_____

Vaccines:

OUR OFFICE IS PRO VACCINE, ARE YOU WILLING TO GET THE AGE RECOMMENDED VACCINES ? Yes or NO

Are you up to date on vaccines ? YES or NO

PLEASE PROVIDE A SHOT RECORD AT FIRST VISIT (THIS IS A MUST HAVE FOR MINORS)